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5	Telephone: (213) 897-6375 Facsimile: (213) 897-2804		
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7	Attorneys for Complainant		
8	BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA		
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12	In the Matter of the Accusation Against: Case No. 2010 - 235		
13	ARCELI N. ANDRADE aka ARCELI NAVAL		
14	1232 Sanborn Avenue Los Angeles, CA 90029 ACCUSATION		
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16	Respondent.		
17	Louise P. Bailey M.Ed. RN ("Complainant") alleges:		
18	PARTIES		
19	11 1 1 1 2 2 CC - in 1 composity on the Interim		
20	1. Complainant brings this Accusation solely in her official capacity as the internit Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer		
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22	Affairs.		
23	2. On or about April 30, 1982, the Board issued Registered Nurse License Number		
24	343524 to Arceli N. Andrade, also known as Arceli Naval ("Respondent"). The license was in		
25	full force and effect at all times relevant to the charges brought herein. The license will expire		
26	on June 30, 2011, unless renewed.		
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JURISDICTION

- 3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

5. Code section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct, which includes, but is not limited to, the following:
- (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."
 - 6. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

PATIENT R.M.

- 8. On or about March 24, 2005, Respondent was employed as a Critical Care Nurse in the Cardiac Care Unit ("CCU") at Martin Luther King, Jr./Charles R. Drew Medical Center ("King/Drew"), located in Los Angeles, California. Respondent and Staff Nurse Johnson-Powell were assigned to two patients each, Nurse Farrell was assigned to one patient who required continuous uninterrupted care, and Charge Nurse Felix Brown assigned himself to one patient. One of Respondent's assigned patients was Patient R.M.
- 9. Between approximately 0400 hours and 0439 hours, Respondent was resting or sleeping in the break room during an unauthorized break period, and Charge Nurse Felix Brown was in the restroom. At approximately 0439 hours, while Respondent was in the break room, Staff Nurse Johnson-Powell discovered that the monitor for Patient R.M. was displaying a question mark and not registering Patient R.M.'s heart rate or other vital signs. The medical records reveal that at 0416 hours, Patient R.M. had become asystolic. His condition went unnoticed for twenty-three (23) minutes until discovered by Johnson-Powell. Johnson-Powell immediately went to Patient R.M.'s bedside and found him unresponsive and without vital signs. Johnson-Powell called for help. After hearing Johnson-Powell's call out for help, Respondent emerged with a blanket wrapped around her and assisted in the resuscitation efforts but without success. At 0513 hours, Patient R.M. was pronounced dead.
- 10. On the Nursing Flowsheet for Patient R.M., Respondent charted as having performed a full systems assessment on the patient at 0400 hours. On the Nursing Progress Notes for Patient R.M., Respondent documented nursing interventions at 0415 hours that she had taken the vital signs, and that the patient was alert, responding and moving left side extremeties. At 0415 hours on the Nursing Flowsheet, (initially written as 0400 hours but Respondent failed

to initial the change to 0415), Respondent charted the patient's vital signs, heart tones (S1 and S2), pulse, and breathing sounds without having observed or evaluated the patient.

CAUSE FOR DISCIPLINE

(Gross Negligence)

- 11. Respondent is subject to discipline under Code section 2761, subdivision (a)(1), as defined under California Code of Regulations, title 16, section 1442, in that on or about March 24, 2005, while on duty as a Critical Care Nurse in the CCU at King/Drew, Respondent was grossly negligent in the following respects involving her care of Patient R.M.:
- a. Respondent demonstrated carelessness and inattention to her duties, by resting or sleeping in the break room during an unauthorized break period, and left the unit inadequately staffed, resulting in Patient R.M. to be asystolic for twenty-three (23) minutes before any nursing intervention was initiated. Complainant refers to and incorporates all the allegations contained in paragraphs 8 10, as though set forth fully.
- b. Respondent falsified Patient R.M.'s medical records, in that she charted that she performed a full systems assessment, including Patient R.M.'s vital signs, heart tones (S1 and S2), pulse and breathing sounds, during the time she was in the break room. Complainant refers to and incorporates all the allegations contained in paragraphs 8 10, as though set forth fully.
- c. Respondent misrepresented Patient R.M.'s condition on March 24, 2005 by posting select portions of the EKG strips and discarded the critical portions which show that the patient had been asystolic for twenty-three (23) minutes without any nursing intervention.

<u>PRAYER</u>

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

- Revoking or suspending Registered Nurse License Number 343524, issued to
 Arceli N. Andrade, also known as Arceli Naval;
- 2. Ordering Arceli N. Andrade, also known as Arceli Naval, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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1	3.	Taking such other and further action as deemed necessary and proper.
2	DATED:	10/22/09
3		Louise R. Bailer
4		LOUISE R. BAILEY, M.Ed., RN Interim Executive Officer
5		Board of Registered Nursing Department of Consumer Affairs State of California
6		State of California Complainant
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